J. Eric Jones, D.D.S.

"The Art of Smiles"

Date______Pt. Name______________________________Referred By________________

Home#________________Cell#________________Text ( ) Email________________

Former Dentist___________________________Last Exam____________________

Notes____

Address________________________________SS#__________________D.O.B.________

Responsible Party____D.O.B.____________

Address____________________________________SS#______________________

Primary Insurance Holder_______________________SS#________________D.O.B.______

Employer______________________Insurance Co.________________________________

Sec. Insurance Holder__________________________SS#________________D.O.B.______

Employer______________________Insurance Co.________________________________

Circle any of the following that you have or have had:

Bad Breath	Bleeding Gums	Loose Teeth
Popping Jaw	Sensitivity to Hot/Cold	Sensitivity to Sweets
Sensitivity when Biting	Broken Teeth	Broken Fillings

Circle any of the following that you have or have had:

Artificial Heart Valves	Surgical Implant	Diabetes	Stroke
Rheumatic Fever	Artificial Joints	Tuberculosis	Chemical Dependency
High Blood Pressure	Chemotherapy	Hepatitis	Tobacco Habit
Pacemaker	Radiation Treatment	HIV/AIDS	Fainting
Kidney Disease	Cancer	Herpes	Material Allergies

Are you pregnant? Y or N Taking Birth Control? Y or N

List medications you are taking:____

List drug allergies:____

Office Policy

Insurance- We will be glad to file any forms necessary to see that you receive the full benefits of your coverage. However, we can make no guarantee of any estimated coverage. Because insurance only pays a portion of procedures, we estimate your part and ask that it be paid at the time services are rendered. After 30 days, any remaining balance is **YOUR** responsibility whether your insurance has paid on your treatment or not. It is also **YOUR** responsibility to inform us of any changes to your insurance coverage.

Self Pay- Payment is due when services are rendered.

Returned Checks- There will be a $25.00 charge applied to all returned checks.

Missed Appointments- There will be a **$50.00 charge** on any missed appointments not cancelled 24 hours in advance. After 3 missed appointments you will no longer be rescheduled.

Fee- A $10.00 fee will be imposed on any account that does not have a zero balance 30 days after their treatment.

Divorce- The party responsible for the account prior to the divorce/separation remains responsible for the account until we are notified otherwise. Any parent bringing a child for services will be responsible for those charges. If the divorce/separation decree states otherwise, it will be up to the parent bringing the child for services to seek reimbursement from them.

Transferring Records- There is a $25.00 duplication fee due prior to picking up the x-rays.

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate treatment. If there is any change in my medical status I will inform the dentist. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits or insure proper treatment by other dental professionals. I furthermore understand and agree to all of the financial conditions previously listed.

Sign and Date____